

Pediatric Medical History Form

Patient Full Name: _____ **Date of Visit:** _____ **OC#:** _____

Date of Birth: _____ **Age:** _____ **Gender:** _____ **Height :** _____ **Weight:** _____

Provider Name: _____ **Pharmacy and Phone #:** _____

Who is your Primary Care Provider? _____ **Who referred you to our office?** _____

Reason for Visit

Please describe the reason for today's visit: _____ **Date Problem Began:** _____

If visit is related to an injury, how did the injury occur? No injury

Fall Sports / Recreation Motor vehicle accident Other: _____

Medical History

None OR **Check all that apply (Use *other** if problem not listed)**

<input type="checkbox"/> ADD	<input type="checkbox"/> Cancer: type _____	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> MRSA
<input type="checkbox"/> ADHD	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Dysplasia of Hip	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Club Foot	<input type="checkbox"/> Heart Disease/Defect	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Delay in Development	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Sickle Cell Trait/Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> HIV/AIDs	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Autism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Difficulty Walking	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Other: _____

List Drug/Food Allergies and Reaction: None Yes If yes, please list: _____

List Current Medications: Please include prescriptions, vitamins or over the counter medications patient is currently taking:

None Yes If yes, please list: _____

List Any Past Surgeries and Date: None Yes If yes, please list: _____

Family History

None **Unknown/Adopted** OR **indicate if any of the patient's blood relatives have had any of the following conditions, check all that apply. (Use *other** if problem not listed.)**

<input type="checkbox"/> Anemia	<input type="checkbox"/> Club Foot	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Delay in Development	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Sickle Cell Trait/Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Autism	<input type="checkbox"/> Difficulty Walking	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Dysplasia of Hip	<input type="checkbox"/> Neurological Disorder	<input type="checkbox"/> Other*: _____
<input type="checkbox"/> Cancer : type _____	<input type="checkbox"/> Gastrointestinal Disease	<input type="checkbox"/> Scoliosis	_____
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Heart Disease		_____

Social History

Lives at home with: _____ Grade in School: _____

Tobacco Use: Yes No Alcohol Use: Yes No Current or Past Drug Abuse: Yes No

General Health

In the past 3 months has the patient had: Fever Rash Infection Required Medication

Has the patient had problems with the same orthopedic problem they are being seen for today? Yes No

If yes, please explain: _____

Does the patient have a current problem with any of the following: (circle "Y" for yes, "N" for no)

Abdominal Pain	Y N	Convulsions	Y N	Dizziness	Y N	Painful Urination	Y N
Arthritis	Y N	Decreased Appetite	Y N	Dry Skin	Y N	Recent Weight Change	Y N
Bleed Easily	Y N	Depression	Y N	Excessive Thirst	Y N	Sleep Disturbances	Y N
Bruise Easily	Y N	Difficulty Breathing	Y N	Headaches	Y N	Vomiting	Y N
Chronic Cough	Y N	Difficulty Walking	Y N	Loss of Hearing	Y N	Worsening Vision	Y N

Has the patient had any of the following tests/procedures related to this problem? If yes, check and provide date.


<input type="checkbox"/> X-ray	____/____	<input type="checkbox"/> Physical Therapy	____/____	<input type="checkbox"/> Pain Management	____/____
<input type="checkbox"/> Myelogram	____/____	<input type="checkbox"/> CAT Scan	____/____	<input type="checkbox"/> MRI	____/____
<input type="checkbox"/> Lab Work	____/____	<input type="checkbox"/> Bone Scan	____/____	<input type="checkbox"/> EMG/NCV	____/____

Pediatric Center Patient Worksheet


Date of Visit: _____ Patient Full Name: _____ OC # _____

Please mark an "X" to indicate the location of your child's pain:

FRONT



BACK



IF YOUR CHILD IS BEING SEEN FOR AN INJURY OR TRAUMA (BROKEN BONE, SPRAIN, SPORTS INJURY, ETC) IT IS NOT NECESSARY TO COMPLETE THE FOLLOWING QUESTIONS.

Birth and Developmental History

Weeks gestation: _____ wks Birth weight: _____ Type of delivery: Vaginal Cesarean Breech

Complications with pregnancy or delivery: None _____

This is my 1st 2nd 3rd 4th 5th Other _____ born child.

Age child sat independently: _____ months Age child walked independently: _____ months

Does your child have any physical or mental disabilities? No Yes If yes, please describe: _____

Special Needs Children

Does your child wear orthotics? No Yes If yes, please specify: AFO SMO DAFO HKAFO Shoe Lift

Other: _____

Does your child attend any type of therapy? No Yes If yes, please specify: PT OT ST

Other: _____

Does your child walk independently? Yes No If no, please specify the type of assistance required:

Wheelchair Stander Reverse Walker Lofstrand Crutches Other

Does your child communicate verbally? Yes No If no, please specify the method of communication: _____

Scoliosis Patients

Who noticed the curve? Parent Patient Physician School Representative Other: _____

Is there a family history of scoliosis? No Yes If yes, please indicate relative: _____

If female, please indicate the date of first menstrual cycle: _____

Does the patient have back pain? No Yes

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